

Senate Bill 229

By: Senators Jones of the 10th, Brown of the 26th, Stoner of the 6th, Seay of the 34th and Davenport of the 44th

A BILL TO BE ENTITLED  
AN ACT

To amend Chapter 7 of Title 31 of the Official Code of Georgia Annotated, relating to regulation and construction of hospitals and other health care facilities, so as to require each hospital, as a condition of licensure, to maintain written policies about discount payment and charity care for financially qualified patients; to provide for eligibility criteria; to provide that each hospital perform various functions in connection with the hospital charity care and discount pay policies, including providing patients with notice that contains information about the hospital's discount payment and charity care policies, and about eligibility and the availability of private or public health insurance coverage for each patient; to provide for billing and collection procedures to be followed by a hospital, its assignee, collection agency, or billing service; to require each hospital to submit to the Department of Human Resources a copy of the hospital's discount payment and charity care policies, eligibility procedures, review process, and the application for charity care or discounted payment; to provide that a hospital director would ensure that a hospital that overcharges a patient will reimburse such patient; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

Chapter 7 of Title 31 of the Official Code of Georgia Annotated, relating to regulation of hospitals and related institutions, is amended by adding a new article as follows:

"ARTICLE 1A

31-7-18.1.

As used in this article, the term:

(1) 'A patient with high medical costs' means a person whose family income does not exceed 350 percent of the federal poverty level if that individual does not receive a

1 discounted rate from the hospital as a result of his or her third-party coverage and has  
2 high medical costs. For these purposes, 'high medical costs' means any of the following:

3 (A) Annual out-of-pocket costs incurred by the individual at the hospital that exceed  
4 10 percent of the patient's family income in the prior 12 months;

5 (B) Annual out-of-pocket expenses that exceed 10 percent of the patient's family  
6 income, if the patient provides documentation of the patient's medical expenses paid  
7 by the patient or the patient's family in the prior 12 months; or

8 (C) A lower level determined by the hospital in accordance with the hospital's charity  
9 care policy.

10 (2) 'Department' means the Department of Human Resources.

11 (3) 'Federal poverty level' means the poverty guidelines updated periodically in the  
12 Federal Register by the United States Department of Health and Human Services under  
13 authority of 42 U.S.C.A. Section 9902(2).

14 (4) 'Financially qualified patient' means a patient who is both of the following:

15 (A) A patient who is a self-pay patient; and

16 (B) A patient with high medical costs.

17 (5) 'Hospital' means an institution which is primarily engaged in providing to inpatients,  
18 by or under the supervision of physicians, diagnostic services and therapeutic services for  
19 medical diagnosis, treatment, and care of injured, disabled, or sick persons or  
20 rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such  
21 term includes public, private, psychiatric, rehabilitative, geriatric, osteopathic, and other  
22 specialty hospitals, but shall not include a facility operated by the Division of Mental  
23 Health, Developmental Disabilities, and Addictive Diseases of the Department of Human  
24 Resources or the Department of Corrections.

25 (6) 'Patient's family' means the following:

26 (A) For persons 18 years of age and older, spouse, domestic partner, and dependent  
27 children under 21 years of age, whether living at home or not; or

28 (B) For persons under 18 years of age, parent, caregiver relatives, and other children  
29 under 21 years of age of the parent or caregiver relative.

30 (7) 'Self-pay patient' means a patient who does not have third-party coverage from a  
31 health insurer, health care service plan, medicare, or Medicaid, and whose injury is not  
32 a compensable injury for purposes of workers' compensation, automobile insurance, or  
33 other insurance as determined and documented by the hospital. Self-pay patients may  
34 include charity care patients.

1 31-7-18.2.

2 Every hospital shall comply with the provisions of this article as a condition of licensure.

3 The department shall be responsible for the enforcement of these provisions.

4 31-7-18.3.

5 (a)(1) Each hospital shall maintain an easily understood written policy regarding  
6 discount payments for financially qualified patients as well as an easily understood  
7 written charity care policy. Uninsured patients or patients with high medical costs who  
8 are at or below 350 percent of the federal poverty level shall be eligible to apply for  
9 participation under each hospital's charity care policy or discount payment policy.  
10 Notwithstanding any other provision of this article, a hospital may choose to grant  
11 eligibility for its discount payment policy or charity care policies to patients with incomes  
12 over 350 percent of the federal poverty level. Both the charity care policy and the  
13 discount payment policy shall state the process used by the hospital to determine whether  
14 a patient is eligible for charity care or discounted payment. In the event of a dispute, a  
15 patient may seek review from the business manager, chief financial officer, or other  
16 appropriate manager of the hospital as designated in the charity care policy and the  
17 discount payment policy.

18 (2) Rural hospitals, as defined paragraph (4) of subsection (c) of Code Section 31-7-94.1,  
19 may establish eligibility levels for financial assistance and charity care at less than 350  
20 percent of the federal poverty level as appropriate to maintain their financial and  
21 operational integrity.

22 (b) Each hospital's discount payment policy shall clearly state eligibility criteria based  
23 upon income consistent with the application of the federal poverty level. The discount  
24 payment policy shall also include an extended payment plan to allow payment of the  
25 discounted price over time. The policy shall provide that the hospital and the patient may  
26 negotiate the terms of the payment plan.

27 (c) The charity care policy shall clearly state eligibility criteria for charity care. In  
28 determining eligibility under its charity care policy, a hospital may consider income and  
29 monetary assets of the patient. For purposes of this determination, monetary assets shall  
30 not include retirement or deferred compensation plans qualified under the Internal Revenue  
31 Code or nonqualified deferred compensation plans. Furthermore, the first \$10,000.00 of  
32 a patient's monetary assets shall not be counted in determining eligibility, nor shall 50  
33 percent of a patient's monetary assets over the first \$10,000.00 be counted in determining  
34 eligibility.

35 (d) Each hospital shall limit expected payment for services it provides to any patient at or  
36 below 350 percent of the federal poverty level eligible under its discount payment policy

1 to the amount of payment the hospital would receive for providing services from Medicaid,  
2 medicare, or PeachCare or any other government sponsored program of health benefits in  
3 which the hospital participates, whichever is greater. If the hospital provides a service for  
4 which there is no established payment by medicare or any other government sponsored  
5 program of health benefits in which the hospital participates, the hospital shall establish an  
6 appropriate discounted payment.

7 (e) Any patient, or patient's legal representative, who requests a discounted payment,  
8 charity care, or other assistance in meeting such patient's financial obligation to the  
9 hospital shall make every reasonable effort to provide the hospital with documentation of  
10 income and health benefits coverage. If the person requests charity care or a discounted  
11 payment and fails to provide information that is reasonable and necessary for the hospital  
12 to make a determination, the hospital may consider that failure in making its determination.

13 (f) Eligibility for discounted payments or charity care, respectively, may be determined  
14 at any time the hospital is in receipt of the following information:

15 (1) For the purpose of determining eligibility for discounted payment, documentation of  
16 income shall be limited to recent pay stubs or income tax returns; or

17 (2) For the purpose of determining eligibility for charity care, documentation of assets  
18 may include information on all monetary assets, but shall not include statements on  
19 retirement or deferred compensation plans qualified under the Internal Revenue Code or  
20 nonqualified deferred compensation plans. A hospital may require waivers or releases  
21 from the patient or the patient's family, authorizing the hospital to obtain account  
22 information from financial or commercial institutions, or other entities that hold or  
23 maintain the monetary assets to verify their value. Information obtained pursuant to this  
24 paragraph regarding the assets of the patient or the patient's family shall not be used for  
25 collections activities.

26 31-7-18.4.

27 (a) Each hospital shall provide patients with a written notice that shall contain information  
28 about availability of the hospital's discount payment and charity care policies, including  
29 information about eligibility, as well as contact information for a hospital employee or  
30 office from which the person may obtain further information about these policies. This  
31 written notice shall be provided in addition to the estimate provided pursuant to Code  
32 Section 31-7-11. The notice shall also be provided to patients who receive emergency or  
33 outpatient care and who may be billed for that care, but who were not admitted. The notice  
34 shall be provided in English. Written correspondence to the patient required by this article  
35 shall also be in each language which is the primary language of 2 percent or more of this  
36 state's population.

(b) Notice of the hospital's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following:

- (1) Emergency department, if any;
- (2) Billing office;
- (3) Admissions office; and
- (4) Other outpatient settings.

31-7-18.5.

(a) Each hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following:

- (1) Private health insurance;
- (2) Medicare; and
- (3) Medicaid, PeachCare, or other state-funded programs designed to provide health coverage.

(b) If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice that includes all of the following:

- (1) A statement of charges for services rendered by the hospital;
- (2) A request that the patient inform the hospital if the patient has health insurance coverage, medicare, Medicaid, PeachCare, or other coverage;
- (3) A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for medicare, Medicaid, PeachCare, or charity care;
- (4) A statement indicating how patients may obtain applications for the Medicaid and PeachCare programs and that the hospital will provide these applications. If the patient does not indicate coverage by a third-party payor specified in subsection (a) of this Code section or requests a discounted price or charity care, then the hospital shall provide an application for Medicaid, PeachCare, or other governmental program to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care; and
- (5) Information regarding the financially qualified patient and charity care application, including the following:
  - (A) A statement that indicates that if the patient lacks or has inadequate insurance and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care; and

(B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies and how to apply for that assistance.

31-7-18.6.

(a) Each hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or an external collection agency.

(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income and monetary assets as limited by Code Section 31-7-18.3.

(c) At time of billing, each hospital shall provide a written summary consistent with Code Section 31-7-18.4, which includes the same information concerning services and charges provided to all other patients who receive health care at the hospital.

(d) For a patient that lacks health care coverage or for a patient that provides information that he or she may be a patient with high medical costs, a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

(e) If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this article.

(f)(1) The hospital or other assignee which is an affiliate or subsidiary of the hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

(2) A collection agency or other assignee that is not a subsidiary or affiliate of the hospital shall not, in dealing with any patient under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital bills any of the following:

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient; or

(B) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to care for himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this subparagraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

(3) This requirement shall not preclude a hospital, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(g) Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills shall be interest free.

(h) Nothing in this Code section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws or any other consumer protections available under state or federal law. This subsection shall not limit or alter the obligation of the patient to make payments from the first date due on the obligation owing to the hospital pursuant to any contract or applicable statute, in the event that the patient fails to make payments for 90 days or to renegotiate the payment plan.

31-7-18.7.

(a) The period described in Code Section 31-7-18.6 shall be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made, if the patient makes a reasonable effort to communicate with the hospital about the progress of any pending appeals.

(b) For purposes of this Code section, 'pending appeal' includes any of the following:

- (1) A grievance against a contracting health care service plan or against an insurer;
- (2) An independent medical review;
- (3) A fair hearing for a review of a Medicaid claim; or
- (4) An appeal regarding medicare coverage consistent with federal law and regulations.

31-7-18.8.

(a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:

- (1) A plain language summary of the patient's rights pursuant to this article and 15 U.S.C.A. Section 1692, et seq., the federal Fair Debt Collection Practices Act. The summary shall include a statement that the Federal Trade Commission enforces the federal act. The summary shall be sufficient if it appears in substantially the following form:

'State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 A.M. or after 9:00 P.M. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at [www.ftc.gov](http://www.ftc.gov).'; and

- (2) A statement that nonprofit credit counseling services may be available in the area.

(b) The notice required by subsection (a) of this Code section shall also accompany any document indicating that the commencement of collection activities may occur.

(c) The requirements of this Code section shall apply to the entity engaged in collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

31-7-18.9.

Each hospital shall provide to the department a copy of its discount payment policy, charity care policy, eligibility procedures for those policies, review process, and the application for charity care or discounted payment programs. The department may determine whether

1 the information is to be provided electronically or in some other manner. The information  
2 shall be provided at least biennially on January 1 or when a significant change is made. If  
3 no significant change has been made by the hospital since the information was previously  
4 provided, notifying the department of the lack of change shall meet the requirements of this  
5 Code section. The department shall make this information available to the public.

6 31-7-18.10.

7 The hospital shall reimburse the patient or patients any amount actually paid in excess of  
8 the amount due under this article, including interest.

9 31-7-19.

10 The rights, remedies, and penalties established by this article are cumulative and shall not  
11 supersede the rights, remedies, or penalties established under federal or Georgia law.

12 31-7-19.1.

13 Nothing in this article shall be construed to prohibit a hospital from uniformly imposing  
14 charges from its established charge schedule or published rates, nor shall this article  
15 preclude the recognition of a hospital's established charge schedule or published rates for  
16 purposes of applying any payment limit, interim payment amount, or other payment  
17 calculation based upon a hospital's rates or charges under the Medicaid program, the  
18 medicare program, workers' compensation, or other federal, state, or local public program  
19 of health benefits.

20 31-7-19.2.

21 Notwithstanding any other provision of law, the amounts paid by parties for services  
22 resulting from reduced or waived charges under a hospital's discounted payment or charity  
23 care policy shall not constitute a hospital's uniform, published, prevailing, or customary  
24 charges, its usual fees to the general public, or its charges to non-Medicaid purchasers  
25 under comparable circumstances and shall not be used to calculate a hospital's median  
26 non-medicare or Medicaid charges, for purposes of any payment limit under medicare,  
27 Medicaid, or any other federal or state-financed health care program.

28 31-7-19.3.

29 To the extent that any requirement of Code Section 31-7-18.1, 31-7-18.2, or 31-7-18.3  
30 results in a federal determination that a hospital's established charge schedule or published  
31 rates are not the hospital's customary or prevailing charges for services, the requirement  
32 in question shall be inoperative for all hospitals, including, but not limited to, a hospital

1 that is licensed to and operated by a county or a hospital authority established pursuant to  
2 Article 4 of Chapter 7 of this title. The department shall seek federal guidance regarding  
3 modifications to the requirement in question. All other requirements of this article shall  
4 remain in effect."

5 **SECTION 2.**

6 All laws and parts of laws in conflict with this Act are repealed.